File Number:
HR11-D-H

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

Date of Injury:
Employee:

Dear

This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A preliminary review has been completed, and it has been determined that the case is not in posture for a hearing at this time. The decision of the District Office has been vacated and returned to the district office for further action as explained in the attached Remand Order.

Your case file has been returned to the Jacksonville District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300

Sincerely,

Electronically Signed

Hearing Representative

PAUL H FELSER, ESQ.
QUEENSBORO BANK BLDG
7393 HODGSON MEMORIAL DR
SUITE 102
SAVANNAH, GA 31406

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

Washington DC. October 31, 2017

U. S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U. S. Code 8101 et. seq. of claimant, employed by the case number

Merit consideration of the case file was completed in Washington D.C. Based on this review, the decision of the district office dated is set aside for the reasons set forth below.

The issue is whether the Office appropriately determined the level of permanent partial impairment of the left upper extremity and left lower extremity based on the weight of medical evidence of the District Medical Advisor, per the AMA *Guides to the Evaluation of Permanent Impairment*, Sixth Edition.

The claimant was employed as a clerk with the when she filed a traumatic injury claiming on she was attacked and physically assaulted in the parking lot. The Office accepted the claim for left hemiparesis, closed head injury, concussion without loss of consciousness. post-concussion syndrome, post-traumatic stress disorder, headache and classic migraine, decubitus ulcer of buttock, and right hip bursitis secondary to favoring the left side due to hemiparesis.

On the claimant submitted a CA7 Claim for Compensation form claiming a schedule award. On the Office referred her for a second opinion examination with Board-certified neurologist, M.D., for an impairment assessment. On the Office's District Medical Advisor (DMA), , M.D., conducted a review as procedurally required.

By decision dated the Office awarded the claimant 5% permanent partial impairment of the right lower extremity based on the review bv the DMA. The claimant disagreed with this decision and a hearing was held on In a decision, the hearing representative affirmed the 5% right lower extremity rating but set aside the decision for further development with respect to left upper extremity and left lower extremity impairment. On the Office's District Medical Advisor, Arnold Berman, M.D., reviewed the medical records and applied the findings to the AMA *Guides*, Sixth Edition.

By decision, the Office awarded the claimant 10% left upper extremity impairment and 10% left lower extremity impairment based on review by the District Medical Advisor. The claimant disagreed with this decision and a hearing was held on

In a remand decision, the hearing representative set aside the decision. She found there was *prima facie* evidence to warrant further development to address whether the claim should be expanded for claw deformity of the left hand, varus equinus of the left foot, and post-traumatic vascular headaches. The representative also found there was medical evidence supporting the claimant had more severe findings on examination since the last exam upon which the prior schedule award was based. The Office was directed to update the Statement of Accepted Facts (SOAF) and refer the claimant for a new second opinion examination to obtain a well-reasoned medical opinion addressing causal relationship for the additional diagnoses and to calculate work related impairment under the Sixth Edition of the AMA *Guides*. The decision is incorporated herein for complete background.

By decision dated the Office formally updated the claim to include the conditions of cognitive communication deficit, left side hemi-anesthesia (disturbance of skin sensation), aphasia, dysphasia, and spastic hemiplegia affecting left non-dominant side. On , the SOAF was updated and case was referred for scheduling of a second opinion examination with an appropriate Board-certified specialist as directed.

On , the claimant was seen for an Office-directed second opinion re-examination with Board-certified neurologist, M.D.[1] Based on her evaluation, Dr advised the claimant's neurological presentation remained the same, except for more spasticity on the left side. She noted this was not uncommon with pyramidal tract lesions. Dr. confirmed with medical explanation that the conditions of claw deformity of the left hand, varus equinus of the left foot, and post-traumatic headaches were directly related to the work injury. She indicated that neither the hand deformity nor the foot deformity added to the impairment since they were the end result of the left spastic hemiparesis, however, no permanent impairment had been assigned to the vascular migraine-like posttraumatic headaches which were due to the head trauma.

Dr. reported that according to table 13-8, page 331, the claimant's cognitive impairment rated 5% class 1 of alteration of mental status, as the claimant had short-term memory impairment and difficulty concentrating. Dr. stated per table 13-9, page 332, the claimant had class 1 of criteria for aphasia or dysphasia, with 3% impairment, for difficulty comprehending what she was told, needing to have statements repeated back to her, and difficulty finding words and understanding script.

[1] The claimant had previously seen Dr. for an Office-directed second opinion examination on

Dr. further reported that for the left upper extremity, the claimant could not maintain grasp, had no finger dexterity, and used the left arm only as gross assist in activities of daily living. She noted that per table 13-11, page 335, she was somewhere between class 2 and class 3, for 15% rating. For the left lower extremity, Dr. stated the claimant had difficulty maintaining her balance and fell, had difficulty with ramps and steps, walked some distance unassisted but was limited to level terrain. Per table 13-12, page 336, she noted the claimant fell somewhere between class 1 and class 1, for 10% rating. For the migraine-like headaches, Dr. used table 3-18, page 342, and noted the claimant's migraines were being treated with symptomatic and preventative medications and were not fully controlled. She stated this would cause mild to moderate disability with a MIDAS score of 10 to 11, which would rate at 3%. Dr. noted that using the Combined Values Chart, page 604, the combined impairment was 32%.

By decision dated the Office expanded the claim for the conditions of left hand claw deformity, left foot varus equinus, and post-traumatic headache.

On I the Office's District Medical Advisor, M.D., conducted a review as procedurally required for impairment ratings. DMA explained that according to the Sixth Edition of the AMA *Guides*, Chapter 13 was the most appropriate chapter with regard to rating the claimant's impairment, as it dealt with the central peripheral nervous system impairment.

DMA indicated with regard to the left upper extremity the claimant exhibited spasticity and claw hand due to over pulling of the flexors compared to the extensors and upper motor neuron spasticity. He noted the claimant could not use her left upper extremity for finger dexterity and could not grasp. DMA explained that based on table 13-11, page 335, this would be Class III impairment and was only provided as a whole person impairment, with 16-30% range based on the fact that this was the claimant's non-dominant arm. He noted she had decreased motor strength, decreased coordination, and decreased dexterity, so that she was unable to button a shirt or lace her shoes. DMA opined this would support 20% whole person impairment for the left upper extremity. He advised that per table 15-11 on page 420 and 421, 20% whole person impairment would equate to 34% left upper extremity impairment.

Regarding the left lower extremity, DMA reported it was documented the claimant had difficulty maintaining balance, was at risk for falling, and had difficulty going up and down ramps/steps. She could walk distance unassisted but limited to level terrain. DMA opined the claimant would have Class II impairment for her gait disorder and given her difficulty walking, would have 15% whole person impairment with regard to the left lower extremity. He stated to convert the 15% whole person impairment to the lower extremity impairment, he used table 16-10, page 530. DMA then stated 20% whole person impairment equated to 39% lower extremity rating. He summarized that the claimant had 49% lower extremity impairment rating and 34% upper extremity impairment for the left side. DMA noted according to the Combined Values Chart, this would equate to a 66% extremity impairment rating.

DMA explained that he agreed that Dr. used the appropriate tables but did not rate the claimant appropriately as she assigned Class II, and he found the evidence supported Class III impairment. He also noted Dr. did not convert her whole person ratings to extremity impairment. DMA advised the date of maximum medical improvement (MMI) was reached on as the measurements and functional history taken on that date were used for the impairment rating. DMA further explained that the range of motion and diagnosis-based methods were not appropriate to rate the claimant's condition and the special circumstances of her clinical situation so Chapter 15 was not applicable in this case. He also noted the documented information did not support current right upper extremity or right lower extremity impairment (0%).

By decision dated , the Office awarded the claimant an additional 24% left upper extremity impairment (34% total) and an additional 39% left lower extremity impairment (49% total) based on the review by the District Medical Advisor. It was noted the claimant had previously been awarded 10% left arm, 10% left leg, and 5% right leg impairment. The claimant disagreed with this decision and by letter postmarked , through her attorney, requested an oral hearing.

Based on my preliminary review of the written evidence, the case is not in posture for hearing and the decision is set aside for the reasons set forth below.

Section 8107 of the Federal Employees' Compensation Act[2] authorizes the payment of schedule awards for the loss or loss of use of specified members, organs or functions of the body. Such loss or loss of use is known as permanent impairment. The Office evaluates the degree of permanent impairment according to the standards set forth in the specified edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[3] For Office decisions issued on or after the Sixth Edition of the AMA *Guides* is used for evaluating permanent impairment.[4]

The role of the District Medical Advisor is to review the report on which the impairment is to be based and to compare the objective clinical findings with the criteria delineated in the AMA *Guides*. He/she reviews the report and verifies the correct application of the *Guides* and confirms the percentage of permanent impairment.[5]

In the instant case, the claimant was previously awarded 5% right upper extremity impairment, which was affirmed by hearing decision. By decision dated , the claimant was then awarded 10% left upper extremity impairment and 10% left lower extremity impairment. This decision was set aside by a hearing decision in order to obtain a second opinion examination to consider additional diagnoses and a current impairment assessment of the work injuries.

[2] 5 U.S.C. § 8107
[3] 20 C.F.R. § 10.404 (1999)
[4] FECA Procedure Manual, Part 2, Chapter 2.808.6.6(a)
[5] *Kandy K. Orwig*, Docket No. 2010-0745

On the claimant was evaluated by Board-certified neurologist, Dr. who had previously examined her for an Office-directed second opinion in Dr. found the claimant's exam had remained essentially the same with the exception of increased spasticity on the left. Referencing the Sixth Edition of the *Guides*, Dr. provided whole person impairment ratings of 15% for the left upper extremity, 10% for the left lower extremity, 5% for cognitive impairment, 3% dysphasia, and 3% for migraine headaches.

As procedurally required, the Office's District Medical Advisor conducted a review and explained why the diagnosis-based or range of motion methods were not appropriate in this case to rate the claimant's conditions. He explained that Chapter 13 of the AMA *Guides*, Sixth Edition was most appropriate and Chapter 15 did not apply. Regarding the left upper and lower extremities, DMA agreed Dr. used the correct tables, but found she did not appropriately rate the claimant based on her class assignment and that she did not convert the whole person ratings to extremity impairment as required. DMA explained how the findings supported Class III and 20% whole person impairment regarding the left upper extremity, which he converted to 34% left upper extremity impairment. DMA then reported the claimant was Class II and had 15% whole person impairment for the left lower extremity. However, his next two statements were, "A 20% whole person impairment equates to 39% lower extremity impairment rating. Therefore, in summation the claimant has a 49% lower extremity impairment rating..."

The Office awarded the claimant total 49% left lower extremity impairment based on the 49% reported by DMA However, I find the District Medical Advisor's statements to be inconsistent and unclear as to whether his reported 15% whole person impairment for the left lower extremity actually converted to 39% or 49%, or neither, as he reported using 20%. This requires clarification to ensure that he used the AMA *Guides* correctly. As long as the DMA explains his or her opinion, shows values and computation of impairment based on the AMA *Guides*, and considers each of the reported findings of impairment, his or her opinion may constitute the weight. The claims examiner must ensure, however, that the DMA properly considers all reported findings, gives rationale, and uses the AMA *Guides* correctly in computing the percentage.[6]

Further, DMA did not specifically address Dr. other ratings of 5% cognitive impairment, 3% dysphasia, and 3% migraine headaches, to explain whether the AMA *Guides*, Sixth Edition and/or the Act support such. The Office was also silent in its decision regarding these ratings.

On remand, the Office should refer the case back to the District Medical Advisor for a supplemental report to confirm that the reprinted 2009 version of the Sixth Edition of the AMA *Guides* was used, and to clarify his conversion of the 15% whole person impairment rating regarding the left lower extremity to a lower extremity percentage.

[6] FECA Procedure Manual 2-0810-7

Washington DC, October 31, 2017

whether it is 39%, 49%, or a different percentage. The District Medical Advisor should also be asked to address the other ratings reported by Dr. . After careful review of the medical evidence and after any additional development deemed necessary, a *de novo* decision should be issued.

Accordingly, the decision dated is hereby set aside and remanded to the district office for actions as outlined above.

ISSUED:

WASHINGTON, D.C.

Electronically Signed

Hearing Representative
For
Director, Office of Workers' Compensation Programs

Washington DC, October 31, 2017